APPLICATION FOR MEDICAL CLAIMS REVIEW AGENT

State
Form 45687 (R2/04-2002)

INDIANA DEPARTMENT OF INSURANCE

For Dept. use only:

Date Fee processed _____

Date license released _____

INSTRUCTIONS:

1. Medical Claims Review Agents are required to provide documentation that they meet each of the statutory and regulatory requirements necessary to be licensed as a Medical Claims Review Agent. Please file that documentation with a completed application checklist, application fee, and this application.
2. Please notify the Department of Insurance of any material change of any information set forth in this application within thirty (30) days of the change. A change in ownership requires a new application, application fee and supporting documentation which should be submitted with the notice of material change.
3. Please TYPE responses to the questions below.

Incorporated name of Medical Claims Review Firm	D/B/A name	
FIN/EIN Number		
Address (include street address and P.O. Box)		
City	State	Zip Code – Nine Digit
Telephone number	Toll-free number (Toll-free number required)	Fax number
Name of contact person	Telephone number of contact person	
E-mail for contact person	Company Website	

Please respond to the following questions by checking the correct response. All answers marked "No" must have explanation attached on separate page.

A. Do you have a working telephone call recording system capable of accepting or recording incoming telephone calls or providing instruction during hours other than normal business hours? ☐Yes ☐No

B. Are all messages left on your call recording system responded to within two (2) business days after receiving the call? ☐Yes ☐No

C. Do you include in the notice of medical claims review determination the principal reason for the determination? ☐Yes ☐No

D. Does your notification of medical claims review determination include a copy of the procedures to initiate an appeal of the determination? ☐Yes ☐No

E. Indiana law requires that a medical claims review agent must protect the confidentiality of medical records of enrollees or covered individuals. Does your organization have written procedures that ensure medical records are kept confidential? ☐Yes ☐No

F. Indiana law requires that a medical claims review agent must "ensure that every medical claims review determination as to the necessity or appropriateness of an admission, a service or a procedure is reviewed by a physician or determined in accordance with standards or guidelines approved by a physician."
Please provide a separate signed statement by a physician licensed in the United States, employed or under contract to your medical claims review firm, verifying that determination made as to necessity or appropriateness of admission, service, or procedure are reviewed by a physician licensed in the Untied States or determined in accordance with standards or guidelines approved by a physician licensed in the United States. In lieu of this signed statement, your firm may provide other appropriate documentation to satisfy the requirement of the law.

Indiana law requires that a medical claims review agent must provide, upon request, a written description of the appeals procedure to a covered individual or enrollee or the person's provider of record. The appeals procedure must comply with the following requirements:

A. on appeal, the determination not to certify an admission, service or a procedure as necessary or appropriate must be made by a health care provider licensed in the same discipline as the provider of record;
B. adjunction to the appeal of a determination must be completed within thirty (30) days after the appeal is filed and all information necessary to complete the appeal is received; and
C. if a medical review determination results in a limitation or reduction of benefits, a notice of appeals procedure shall be provided by the medical claims review agent to the provider who rendered the health care services.

Does the appeals procedure of your firm meet the above standards? ☐Yes ☐No

I certify that the above statements are true.

Signature of applicant	Printed name of signature	Title